they are poorly trained and feel inadequate or they are given other responsibilities that they feel are demeaning. The one encompasses scheduling, making assignments, responding to doctors' orders and the like; the other includes bed making, answering call bells and emptying bedpans. Somehow in high school and in college, prospective nurses are misled and are given the idea that they will be responsible for patient care, while in practice nurses must carefully follow prescribed administrative guidelines, nursing association guidelines and physicians' orders that they may or may not agree with. The rest of the time they act as housemaids. Individual initiative has no place in this scheme.

All this adds up to the fact that nursing is no more a profession where individual responsibility is placed at a premium with commensurate reward than is bus driving or any other service that has significant personal responsibility. Nursing schools, which are now exclusively the province of universities, take great pride in separating nursing education and nursing responsibility from the field of medicine and its specialities. They attempt to justify all of this by calling nursing "a profession." When the first university nursing school was established at Johns Hopkins in the 1890's the direction was established by a nurse, separating it completely from any input from the medical staff, creating a pattern that has resulted in the virtual elimination of all nonuniversity training programs in this country. A professor of nursing with a PhD in nursing recently announced with pride when asked whether physicians take part in her educational program at a large midwestern university: "We have nothing to learn from doctors!"

A glance at the modern nursing school curriculum at any university will make it easy to understand why nursing care in hospitals is generally regarded so poorly. Recent graduates are so ill-prepared to take care of the nursing needs of a patient that they must spend two to three months in a preceptorship program in a hospital before any responsibility can be given whatsoever. Erudite term papers on the philosophy of illness and the biology of cancer prepares a nurse in no way for what she is going to face once placed on the ward. The perennial complaints of any patient in a hospital quickly confirms this. The poor preparation to deal with the patient and his everyday needs is reflected in the usual delay of nurses to answer call bells and the frequently apparent callousness in responding to patients' "unreasonable demands." Adding insult to injury, many nurses are now being requested to manage highly sophisticated computers for orders and information retrieval for which they have no particular interest or training. This is a perfect formula for the alienation of the present hospital staff nurses from their job.

Again, the unreasonable expectations and the inappropriate training of present-day hospital staff nurses is responsible for the nursing crisis, as I see it. Increasing salaries and fringe benefits will have no effect. Nursing training must shift gears. In the meantime, we shall see everyday nursing responsibilities taken over more and more by licensed vocational nurses and others who are not burdened with irrelevant education. Administrative responsibilities will be taken over by those who are particularly trained. The path has been blazed in the military where there has been a perennial shortage of registered nurses.

The nursing "profession" should be reminded of Walt Kelley's character Pogo when he said, "We have met the enemy and he is us."

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Nutrition Cultism

TO THE EDITOR: It was a pleasure to read Dr. Victor Herbert's incisive attack on nutrition quackery.[1] He correctly identifies the hazards of a 10 percent fat diet which excludes basic food groups such as milk, meat and the "energy group" (fats, alcohol and sugar). The American Medical Joggers Association reviews deaths of marathon runners, and has collected more than two dozen reports of rhythm problems associated with low-fat diets.

Our prospective study of 167 marathoning cardiac patients now represents 1,000 patient-years with deaths numbering seven (0.7 percent per year). Three of the "most improved" patients died "rhythm" ("electrical") deaths when they trained on low-fat diets. After a period of falling body weight and serum cholesterol, they experienced irregular pulse and nonspecific weakness. Although they complained of "running poorly," they usually died at or near their highest level of fitness; hence the term "elite runner's arrhythmia."[2]

As the hobbies of running and dieting become more popular, we expect to see an increase in the numbers of these "nutritional arrhythmias." The

present rate of case accumulation is about six per year. We speculate that a low-fat diet is deficient in the essential fatty acid linoleic acid, which is important in the prostaglandin pathway where it exerts antiarrhythmic effects.[3]

It is to be hoped that Dr. Herbert's attack will dampen the public's enthusiasm for fad diets.

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The Value of Neurological Consultation

TO THE EDITOR: Bodily and coauthors, in their article in the September 1981 issue,[1] recommend ultrasonic arteriography "in those patients with atypical symptoms that may represent ischemic neurological events." Further, they advise that "should a significant stenotic lesion be identified, endarterectomy could then be offered. . . ." Since "significant (carotid) stenosis" is often asymptomatic, this finding, whether by invasive or noninvasive testing, does little to clarify the nature of "atypical" symptoms. Where prior neurological consultation is appropriately obtained, candidates for vascular studies with such "atypical" symptoms, should be few indeed. Those whose symptoms remain "atypical," or of uncertain significance, should be evaluated and reevaluated by appropriate consultants for as long as it takes to clarify whether or not they have organic disease and, if so, whether or not their disease is vascular. Only when a vascular basis for a patient's symptoms seems likely on clinical grounds is it appropriate to apply vascular testing.

As a neurologist, I am troubled by the increasing espousal by vascular surgeons of the nebulous concepts of "atypical" and "nonhemispheric" stroke and transient ischemic attack.[2] The difference of opinion between neurologists and vascular surgeons in regard to carotid endarterectomy is not so much a matter of conservatism versus liberalism in the application of surgical procedures as it is a frank disagreement over diagnostic concepts.

A diagnostic scheme not including prior neurological consultation neither serves the best interests of patient care nor advances knowledge of cerebrovascular disease.

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Palindromic Asymmetric Polymyalgia Rheumatica

MOST AUTHORITIES consider that a diagnosis of polymyalgia rheumatica can be made clinically on the basis of aching, stiffness and tenderness of proximal musculature, as well as prominent morning stiffness of at least one month duration in middle-aged to elderly patients with elevated sedimentation rates.[1] I wish to describe a case that fulfills the above criteria, yet the patient presented with well-defined asymmetric clinical attacks.

An 82-year-old white woman was evaluated for hypersomnia, a weight loss of 4½ pounds (from a base of 87 pounds), and episodic shoulder and hip girdle muscular stiffness and soreness. The musculoskeletal symptoms had been present for six months before the consultation. During the month preceeding her presentation, the symptoms had become well-defined into attacks that lasted for three to four days, resulted in almost total immobility and were separated by approximately one-week intervals during which there was a relative return of function. In addition, the attacks occurred predominantly on the right side. The patient had noted no cranial symptoms suggestive of temporal arteritis. She was otherwise well and had not seen a physician in many years.

On physical examination there was no synovitis or muscle tenderness or weakness but decreased mobility of the shoulder and hip joint was noted. The remainder of the findings were noncontributory. Laboratory studies showed a Westergren sedimentation rate of 80 mm per hour (repeat of 86 mm per hour), normal complete blood count and chemistry panel, normal free thyroxine index and absent rheumatoid factor. The patient was begun on a regimen of prednisone (30 mg a day by mouth) and within two to three days there was a dramatic clinical response with greatly increased mobility and disappearance of muscular soreness. Sedimentation rate decreased promptly and has stabilized at approximately 35 mm per hour. During the past five months, the prednisone